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# Exploring the Task Shifting Potentials of Non-Health Community Based Providers of Comprehensive Maternal Health Services in Urban Slums in Federal Capital Territory, Nigeria: Community Survey

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**Abstract:** In Nigeria, there is high fertility and low contraceptive prevalence. This study was conducted to explore the perception and experiences of delivering comprehensive maternal health services including family planning, safe abortion and post abortion care services in three urban slums of FCT, Nigeria through community based Adolescent Girls and Young Women (AGYW) non - traditional health care providers linked to female managed maternity homes. The study documented the baseline information that explored the potential task shifting benefits of community-based access to Family Planning and Therapeutic Safe & Post Abortion Care services among Adolescent Girls and Young Women in low resource settings – urban slums. The study adopted both qualitative and quantitative study design. covered 60 Key Informant Interviews conducted amongst community-based health providers working in private hospitals/clinics, primary health care facilities, pharmacies and patent medicine vendors shops; and 18 Focus Group Discussions conducted amongst adolescents' girls and young women in female dominated vocations; whilst, a total of 540 respondents were questioned in 3 urban slums of FCT, Nigeria. Providers had adequate knowledge of the reproductive and sexual health challenges facing adolescent girls and young women in their communities but there are limitations to service provision to address the identified challenges. These limitations varied from lack of basic training on family planning and safe therapeutic abortion, family planning commodity stock-outs, poor health seeking behaviour of clients and constraints in community outreach. There was a sense of reluctance to mention the use of misoprostol for termination of unplanned pregnancy among the providers which could be attributed to the associated perceived or socially constructed immorality and criminalization of abortion in Nigeria. Though traditional community health workers are knowledgeable and able to counsel young women and girls about their reproductive health concerns, majority of them are prescriptive, morally biased or lack current information on the issues relating to family planning and safe abortion. These community based health providers need proper orientation and further training and supportive supervision in order to improve the quality of care they offer. Adolescent girls and young women (unmarried or married) are vulnerable populations that providers need to be better educated about and trained on how to meet their reproductive and sexual health needs. Given the unhindered access which female artisans have among adolescent girls and young women either as clients or as apprentices, enhancing their reproductive and maternal health knowledge and counseling skills will positively affect the general health and well-being of the girls and women.

**Keywords:** Family Planning, Safe Abortion, Community-Based Providers, Urban Slums, Nigeria

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## I. INTRODUCTION

Access to all forms of family planning and safe abortion services represent critical facilitators of sexual and reproductive health and right. In many parts of the globe, there remains substantial unmet need for contraception as well as considerable legal barriers to safe abortion[1].Unsafe abortion is defined by the World Health Organization[2] as a procedure for terminating a pregnancy performed by persons lacking the required skills or in an environment not in conformity with minimum medical standards or both. It is a leading cause of mortality and morbidity among women of reproductive age. In Nigeria, unintended intercourse is the primary cause of unwanted pregnancies, and many women with unwanted pregnancies decide to end them by abortion[3]. Since abortion is illegal in Nigeria (unless medically recommended to save a woman's life), many

abortions are carried out clandestinely, and often in an unsafe environment[4]. Induced abortion is not only widespread in Nigeria but also provided and practiced in a number of different settings, from traditional practitioners, herbalists, and private practicing clinicians to modern pharmacists[5]. The consequences of these clandestine abortions are grave and can be life-threatening, often leading to maternal death.

Contraceptive use remains an important way to reduce the rate of unsafe abortion by preventing unwanted pregnancy, but the use of contraceptives is still very low in Nigeria with only 16%[6] of women in the reproductive age group using any contraceptive methods[6]. This therefore results in about 30% of these women experiencing unwanted pregnancy in their life time[5]. Studies also show that the main reason for not using contraception in Nigeria is lack of adequate knowledge and poor accessibility to family planning commodities. The situation is even more pitiful in rural areas and urban slums where health facilities are scarce and reproductive health services are limited.

Health Service provision in Nigeria span a wide range of health facilities, professions and skill levels. Hospitals and clinics can be either public or private entities but all primary health care (PHCs) facilities are funded by the government. The private sector also encompasses patent medicine vendors (PMVs) and pharmacies. The selection of services offered also varies per facility. PMVs are only allowed to stock condoms and to re-supply oral contraceptive pills, pharmacies can dispense pills and in some cases provide injectable while hospitals can offer a greater number of contraceptive methods[7].

Strengthened collaborations and effective referral linkage between traditional and non-traditional health care providers such as birth attendants, community health workers and women artisan groups to facilitate distribution of contraceptives and abortion medications in the communities is a task-shifting option[8] that could reduce unwanted pregnancy and the associated maternal morbidity and mortality from unsafe clandestine abortion[9].

This baseline study was therefore conducted to provide the basis for designing cost effective interventions for community-based access to Family Planning and Therapeutic Safe & Post Abortion Care services among Adolescent Girls and Young Women (AGYW) in urban slums in Nigeria as precursor to the Proof of Concept.

## II. METHODS

The study adopted both qualitative and quantitative descriptive research design carried out in three urban slums of the Federal Capital Territory (FCT) of Nigeria namely Mpape, Kubwa and Nyanya. A total of 60 Key Informant Interviews (KII) were conducted among health providers working on maternal health and family planning, in both public and private sector comprising of nurses, community health workers, community pharmacist/patient medicine vendors; whilst a total of 18 Focus Group Discussions (FGD) were conducted among adolescents girls and young women in female dominated vocations such as hair dressing/styling, fashion design and tailoring services, catering services etc within the age group of 15 - 30 years.

A 10 question KII & FGD guide was used and contained an introduction of the researcher and full disclosure of the survey, ethical considerations as well as request for consent. The KII guide explored issues relating to reproductive health services currently offered, common reproductive and sexual health challenges among adolescent girls and young women in the selected communities, family planning and safe abortion services provision and recommendation for modern contraceptives and safe abortion service uptake improvement. Similarly, the FGD guide explored issues relating to their knowledge about the sexual and reproductive health challenges of adolescent girls and young women in the communities, knowledge and experience sharing on family planning and safe abortion services, information transmission channels and recommendations for increased demand and uptake of these services. The information from the KIIs &FGDs were transcribed and analyzed for themes and contents.

Questionnaires for the quantitative interviews were administered to a total of 540 interviewers. Semi-structured questionnaire were used for the survey. Validated semi-structured questionnaire was given to the respondents in their place of work/vocational centres within the study locations. Respondents who were unwilling to participate were exempted from the survey and were replaced with other willing ones within the community. There was a total of 42 questions and these were divided into four sections; the first section generated information on the socio-demographic data of the respondents; the second section assessed respondents' sexual activity and pregnancy outcome history; the third section also assessed their knowledge and practice of family planning and safe therapeutic abortion services while the fourth section explored the respondents' attitude and perception towards family planning and abortion services as well as acceptability of community based access and provision of these services.

Information gathered from the questionnaire was cleaned and coded for data entry. It was then entered and analyzed using SPSS (Statistical Package for the Social Sciences) software version 17.0. The quantitative data were analyzed for frequency of occurrence.

Ethical approval was obtained from the Health Research Ethics Committee (HREC) of the Federal Ministry of Health. The research team ensured privacy during the interviews and discussions as well as in reporting of data. Consent was obtained from all participants by explaining the full extent of the survey and having them sign the consent form.

## III. RESULTS

**Key Informant Interviews (KII)**

***Sexual and Reproductive Health Challenges and Services Provided in facility/store***

Unwanted pregnancy topped the list of SRH challenges faced by adolescent and young women in the communities as identified by the informants. Other SRH challenges identified by the informants included: rape, financial challenges resulting in indiscriminate sex for money, abortion, STI/HIV, home delivery, socioeconomic status resulting into poor health seeking behaviour and ignorance of available services.

*"in terms of them getting unwanted pregnancy, that same age (group), I think most of them maybe it's because of their parents, their school or may be the person is not responsible, they will just want to do abortion, most of them doesn't keep it. If you ask them, my school, my parent, the person is not ready and we keep on advising if you know the person is not ready why can't you protect yourself. If really you can't hold yourself then you protect yourself"*

Another informant attributed the non-use of contraceptives to the prevalence of unwanted pregnancy:*"the challenge here is the issue of family planning, we experience very huge challenge there, both women and the young girls, you see them taking in, having unplanned pregnancy just because they don't want to go on contraceptive, giving the reason that it might hinder their chances of conception when they want to have children. So it's ignorance on the part of those young children and some mothers. That's the challenge we have here because they are naive about the contraceptive work and because of the misconception they heard about ".*

The sexual and reproductive health services offered in public and private health facilities visited varied from ante-natal care, deliveries, postnatal care including immunization, family planning services, ART and post-abortion care. However there were some services that public primary health care facilities are not allowed to provide and on such cases they refer to a general hospital. Such services include post-abortion care and sterilization method of family planning – tubal ligation and vasectomy.

Apart from the on-site services provided, an informant added that the health centre had provision for community outreaches especially in the area of family planning and immunization to provide services for clients and also follow up defaulters.

Informants from pharmacy and patient medicine stores reported that the service provided is mainly the sale of medications/drugs to clients. Another informant however reported some level of maternal health counseling.

Other comments around SRH challenges include the following:

"*I think it is childbearing, women give birth a lot, as in you see a woman that cannot even feed herself or the children and the woman will be having like 5 children, you know it's uncalled for. That's the problem we have, when the woman is not well fed, how can you take care of your baby or your pregnancy or yourself. I think that is the most cases of maternal issue we have. If women can be enlightened about child spacing and number of children for them to be able to cater for I think it will do a lot".*

***Family Planning Service Uptake***

The methods of family planning offered at the facilities/medicine stores vary as reported by the informants. The public PHC facilities and some private clinics offer almost all of the methods ranging from condom, oral pills, injectable, implants to IUDs except sterilization. Informants from a pharmacy store reported the sales of condom, oral pills and injectables while their counterparts from patient medicine stores reported the sale of condoms only and some sell oral pills refills too.

The method with high uptake rate is the injectables as reported by the informants. This is so because although it is short term, it does not require daily dosage as oral pills which could easily be forgotten thereby losing its efficacy.

*'I think it's injectables, it depends on individual, some people will say the oral pills I will forget, you know it's a daily something, so they prefer the injectables for 2-3 months. Some have fear of carrying the implant based on misinformation. Then the IUD is the same misinformation. Some will say how can I be touching rope inside my body all the time. I think it is a displeasure or so. They don't want any foreign body on their body, so they prefer the injectables'*

Another reason for high uptake of injectables as reported by the informants is the influence of peers from the community:

*"So most women it is what they hear in the community, even though they hear it in the clinic but they prefer the one they hear in the community, ha, my sister, my friend has said so, me ok, it's this one that I want to do. Some when they come, before you explain, ma this is what I want to do, they've already made up their mind that this is the one I want to do".*

On the issue of feedback received from clients about safety as it affects method continuation when users expressed worries, the informants reported the following:

'*There are complaint about side effects. There is a particular client that I know she has tried it all and none is favourable to her, she just has to go on natural. The complaint was that she was bleeding a lot, sometimes in a month she will bleed like 3 times'.*

***Issues around Family Planning Commodities Supply and Availability***

For public PHC facilities, family planning commodities are supplied by the government upon requisition, however there are stock-outs for majority of the commodities.

An informant while lamenting on the situation reported thus "*before they* (government) *were giving us regularly after 2, 3 months but this year they brought only 2 cartons of Depo*(injectables). *The supply is low compared to demand"*

Another supported the supply channel with the report:

*"we get commodities from Government and NGOs, and it is not regular, it is when they like and it is not what you requested for that you get. I've been in family planning for the past 18 years or so. Initially you request on your own, you go to collect, they will give you your transport money. When some group of people called LMIS* (FP-Logistic Management and Information System) *came up, it turned out to be something else. You will request and send to them, what you requested for is not what they will send to you, what they can give is what they will give. Like my last requisition for this clinic was much, the only thing they supplied was 25 syringes and that was all... It's what NGO gave us that I share and I know it will soon finish. The service is free, but products are out of stock'*

For other private hospitals, pharmacy and medicine stores, it was reported that procurement is made from wholesale Pharmacy store and that sale is made at 10% profit based on the cost of procurement.

***Request for Abortion and Post Abortion Care Services***

Majority of the informants reported request for abortion among clients with unwanted pregnancy but none of them reported the provision of safe abortion service.

*'They come requesting for abortion but we don't do it, both single and married, they will say my baby is still small and I don't want another baby but we advise to keep the pregnancy and I wouldn't know what they do after the counseling'.'* -Informant from Private Clinic

*'Some of them do come but we don't attend to such cases here. It's not our duty in the pharmacy to attend to such cases. We refer them to hospital'* - Informant from pharmacy store

Only private hospitals reported the provision of post-abortion care service while public PHCs reported referral of all abortion and post abortion relation cases to the nearest Government General Hospital.

Also, it is noted that majority of the informants do not support abortion service provision: "*...use condom if you don't want to get pregnant than carrying that innocent child, go out to flush it there. I think it's not advisable. Most of them if you try to advise them, you won't see them in this your pharmacy again"*

***Perceived Use of Misoprostol***

Majority of the informants had a good knowledge of the use of Misoprostol. The reported uses include termination of pregnancy, to induce labour and management of postpartum haemorrhage. Others reported its use for typhoid and ulcer.

*"It can be used for ulcer, control of postpartum haemorrhage, it can also be used for retained product or maybe inevitable abortion or something like that. Those are the things I know. It can be used for inducing labour".*

An informant in a hair dressing saloon patient explained that '*I know misoprostol, I was working in hospital before, so I know. They were using the drug for abortion to make the baby to come out, sometimes also if a woman is in labour and she is unable to deliver, they give her the drug for the baby to come out. They will insert it or they will swallow it. It's often like that but on critical condition'*

***Bias against Unmarried Adolescent Girls and Young Women***

Providers often purposely excluded unmarried youth and young women from their family planning services. While most did not provide justification for withholding family planning from these groups, concerns about promiscuity were mentioned.

*"Let me say you can advise them to be going on condom. I think FP is not good for youth that is my own understanding. it's mainly for married women. I think they should go for condom, that will be safer for them"–* Female fashion designer

***Recommended Demand Generation Strategy for Increased Uptake of Modern Contraceptives***

The need for health education campaigns to address issues on the health benefits of contraceptive use, dispel the misconceptions and alleviate the ignorance and fear of side effects were emphasized among the informants.

"*Health education gathering (religious or any form) to educate them, change their mindset that will go a long way in helping the community rather than training personnel to stay with the knowledge"* Female Caterer

To address the issues around commodity stock-outs, regular and adequate supply of family planning commodities was recommended.

"*lack/shortage of commodity reduced the client flow, so there should be regular and adequate supply of commodities to meet the needs of the clients and there should be follow up of defaulters, provision of commodities is number 1, even if you have stipend to go to community what are you going to give them. Two, let them make provision for us to be visiting, that is outreach or home visiting..."* Female PHC clinic in charge

Another recommendation for improvement is the use of community leaders to mobilize the adolescent girls and young women.

**Focus Group Discussion (FGD)**

**Sexual and Reproductive Health Challenges faced by Adolescent Girls and Young Women**

The sexual and reproductive health challenges of adolescent girls and young people as highlighted by the discussants were unwanted pregnancy, unsafe abortion, under-age motherhood, sexual assault e.g. rape and illicit sexual relations. Unwanted pregnancy was a major challenge as reported by the discussants:*"Most challenge is unwanted pregnancy, like when a guy talks to a lady, that I like you and next they go into sexual intercourse and they get pregnant, what they don't really want happens".'*

Another discussant emphasized the desire for sexual relations among the group: '*They like sex na, it's all about sex and they like it. This is because some of them don't have money, they use that to help their self. Most of them they don't have parents, by the time they go out, they do one or two things so, some will not get pregnant o, some will but they will abort it.'*

General discussions on the SRH challenges are as follows:

*'YAPA o, unwanted pregnancy, different type of infections, sickness. You know some when they want to go and abort pregnancy they lose their lives'.*

'*Mostly sometimes rape, like taking advantage of someone without their consent. Sometimes they go into drug abuse, may be someone rape her, she will go crazy not really crazy, she will be like let me kill myself because all those things is looking dramatic to her'*

*'That's why I said things have advanced, nowadays, if you see the position they say if they stay during sex, if they release after sex the stuff will not enter. So now the rate* (abortion) *has reduced compared to then that everybody use to get pregnant, some will just do abortion while some who are too scared of abortion will give birth. But a*

*lot of things have come, some people will even go to hospital, you see young girls will go and take injections for family planning just because they want to be having sex freely and not get pregnant.'*

*'I want to talk about unwanted pregnancy, from what me I observe, I observe that in urban area it has reduced drastically, but then in rural areas, I'm saying it based on what I've seen, I worked in Karu and I saw some girls, it was as if they were doing competition, all the girls in that area, you see this one she is pregnant and this next I'm coming you see another one pregnant, it was just as if they are doing competition. It's not even unwanted, it's like they are doing it deliberately. In some areas it is still increasing, because some people don't even have that knowledge of protecting themselves. Even the ones that protect themselves, at times condom fails'*

According to the discussants, there are no available service to address the identified challenges faced by adolescent girls and young women in the communities: *There is no service, people don't open up because they are afraid of how people will look at them or judge them, they can't even talk to their parent, you might go into the hospital and the way the health workers will look at you. If there is a way they can make abortion legal, I'm not saying it's right but we know they are doing it but to make it safe. In America now, if someone is pregnant maybe in early stage, they go there and I don't want this child, may be for certain reasons and even when you want to keep that child we don't have institutions where we cater for such, that's why you see them throw their child away, we don't have that kind of institution here which I feel is bad'*

Another discussant attributed the lack of service to inability of the young women to open up on issues especially SRH*: 'Most people think if you bring such they think you are a bad person, baddest person or even a prostitute, that's why most girls are feeling shy to talk about it'.*

**Perceived Understanding of Family Planning and methods**

There was a unanimous understanding of family planning among the discussants, although the knowledge about the various methods differs among them. Also, there was an almost general belief that family planning is meant for married women only.

*'Me I know that family planning is if you don't want to give birth anyhow. I've heard of injection, pills and there is the one they will open your stomach, there is one they put here* (demonstrated with the hand pointing to the upper arm*) ehn implant, I watched 'Shuga' and I heard them talking about that one'*
*'What me I understand about family planning is that when you are married and you have given birth to the amount of children you want, you don't want more, I don't know where they do it o but they will give what will control so that pregnancy won't come'*

*'From my own understanding, FP is not good for a young lady why, its constant use that it will get to a time that when you take in, it will flush out, miscarriage because it has advantages and disadvantages. There is this woman that I know, she even put the one here* (implant)*ehn when she was due to marry and start borning*(giving birth) *she will take in the thing will go. When she now go to scan, they said it's because of the family planning she was taking, she spent a lot of money, so it's not advisable for young girl that is still single'*

*'We have pills, IUD, eehn Injection, calendar method, withdrawal method'*

*'Family planning is mainly done by partners, according to Biology that we did in school, it is mostly done by couples, married couples that go into this methods, all these to know the interval of their children childbirth'*

While sharing their experience on the use of family planning service, a discussant reported that: '*everybody here have used the condom, the other ones are for married women. You have not used any of them, don't mind them'.* Another discussant shared her experience on the use of calendar method: '*I normally count the day I'm ovulating, yes the calendar method, the day I'm not on free period, I won't do anything, I will tell him. even if he says he want to use condom, I will say I'm not doing. I will know because my breast will be full and painful'.*

Majority of the discussants were sexually active and had used at least one method of family planning. Another discussant while sharing her experience reported: '*everybody here don have sex, we don't use family planning, na only condom, I no go lie you sha before I marry I take pills'.*

The few discussants who had accessed at least a family planning method reported ease of access and confidentiality: '*I am an adult, they only tell me how to take it and they ensure your privacy'.*

**Preferred outlet for distributing family planning services**
Majority of discussants preferred chemist and patent medicine vendors as best outlets because they will not ask for card registration and consultation fee like clinics and hospitals which make the service expensive.

**Perceived Understanding of Safe/Unsafe Abortion**
Majority of the discussants had limited understanding of what safe abortion means. However, the universal understanding was the removal of unwanted pregnancy as reported by the discussants: *'To comot belle na, if you don't want to keep the child you flush it out'*

Other discussants queried the perception of safety in abortion with comments like:
*'Safe abortion?Abortion get safe?*

*Is there anything like safe abortion sef? Lol because it's like taking risk when you go to doctor or 'aboki', you dont know if that is what will kill you or not. Me I don't even know o'*

Others reported safe abortion as the procedure carried out in the hospital with the doctor's recommendation: *'If you go to national hospital, if doctor tell you say you have to abort this baby that na safe abortion, unsafe abortion is when you go to quack doctor'*

Another discussant reported tha*t 'unsafe abortion is when maybe you are pregnant and you want to abort the baby and in the process...maybe you go to the hospital, there are some doctors that may be when they operate you to bring out the pregnancy, they might forget one or two things inside or they will cut something that are not supposed to be cut out, maybe in that process you die or there are some that after those abortion they will start bleeding or some take pills and they will start having problems from that'*

**Perceived Use of Misoprostol**
Majority of the discussants had no knowledge of misoprostol and its use:
*'I'm hearing of it for the first time'*
*' this is the first time I'm hearing the name.*

However, the few discussants that had heard about it had good knowledge of its use.

*'I heard about it and it's for abortion right? but it is risky because you bleed a lot'*

*'I have heard, it's act on the uterus. You can use it to prevent postpartum haemorrhage, you can use it to do abortion, you can use it to induce labour. I'm a nurse and I've used it to induce labour'.*

*'I have heard about it, it is a kind of abortion drug to flush a pregnant you don't want', I heard it's also used for typhoid'*

A discussant while learning about the medication for the first time reported support for its use: *'I think that is even better than taking all these pills, you see some people it's by mistake and some it's by rape, so you don't blame them'*

None of the discussants with knowledge of misoprostol reported previous use.

**Barriers to accessing Family Planning and Safe Abortion Services**
Majority of the discussants were of the opinion that adolescent girls and young women are ignorant and are not aware of the accessibility to family planning and safe abortion services especially the unmarried ones.

*'Maybe they don't know they can use, maybe they think it is for married people because me too I'm just hearing it now'*

*'Some are ignorant and they ask friends who give wrong advice. That's why some of us don't have access to know some of it'.*

*'Due to illiteracy, illiteracy has caused a lot of them not to'*
Others reported that fear of what people will say and shyness could also be barriers to accessing these services.

*'Some might be scared that if I go to this pharmacy and people see me, they will report me to my parent that they saw that I bought this thing here'*

*'Many people lack knowledge and some people think it is a shy topic, they don't ask and a closed mouth is a closed destiny'*

**Preferred outlet for safe and post abortion care services**
Discussants that have had abortion experience preferred self-administered medication; chemist/patent medicine vendors dispensed drug; private clinic conducted surgical procedure in that order because they guarantee greater privacy to the client. Majority of abortion experienced discussants mention that counseling by peers regarding what to do and where to go for services when unplanned pregnancy occurs play a major role in the decision process by affected girls and young women.

**Recommendations for addressing Identified Barriers to Family Planning and Safe Abortion Services**
Majority of the discussants recommended the need for awareness creation and health education programmes on the availability and accessibility of family planning and safe abortion services through the various channels of information transmission with emphasis on the use of social media.

*"'There is need for health education, creation of awareness. you know some ladies, they are shy, and if you are talking to them, they will say this girl is spoiled"*
There were also recommendation for parent and peers whose influence are believed to play important roles in increased access to these services.

"*...to know more they go online because they are afraid to ask friend so that they will not mislead them but if you have a mother and sister that can encourage you about it' it helps"*

Availability of service centers within the communities was also recommended: "*If there can be an organization or clinic where someone can go, most people prefer going to a nearby place, with someone to talk to, someone to interact with. Most prefer such places than going to the hospital because they are not sick"*

Community channels of information dissemination as reported by the discussants include the following: social media, youth groups, religious gatherings, workshops and place of work especially where young girls gather for vocational apprenticeship.

**Quantitative findings:**
**Socio-demographic information of respondents:**
The respondents ranged in age from 15 to 30 years with a mean of 22.6 ± 4.3 years SD. Majority (83.3%) were females while 16.7% were males. A large percentage (71.7%) of the respondents was single while only 28.3% were married. Their highest educational levels were primary (4.4%), secondary (69.4%) and tertiary (25.0%). Majority (84.4%) of the respondents were Christians while 15% were Moslems. Majority (58.9%) of the respondents were into fashion designing and tailoring while others include hair dressing (31.1%) and catering services (4.4%). Also majority (71.1%) were apprentices while 26.1% were self employed.

**Sexual Activity and Pregnancy Outcome**
Over half of the respondents (66.7%) were sexually active and 84.1% of the sexually active respondents were females and 43.5% of these females had been pregnant before (See Table 1)

**Table 1: Respondents' Sexual Activity and Pregnancy History**

| | **Sexual Activity** | | |
|---|---|---|---|
| | **Yes** | **No** | **Total** |
| **Male** | 57(10.6%) | 33(6.1%) | 90(16.7%) |
| **Female** | 303(56.1%) | 147(27.2%) | 450(83.3%) |
| **Total** | 360(66.7%) | 180(33.3%) | 540(100.0%) |

| | | | |
|---|---|---|---|
| **Ever pregnant** | Yes | No | Total |
| | 132 | 171 | 303 |
| | (43.5%) | (56.4%) | (100.0%) |

**Knowledge and Practice of Family Planning Services**

Awareness of family planning was high among the respondents (93.9%). A large percentage (84.4%) of the respondents had an understanding of what family planning means or used for. Respondents' meaning of FP included: to avoid/prevent unwanted pregnancy, to reduce the rate of childbirth, spacing /limiting childbirth and couples planning for the future of the family to determine the number of children they want/desire.

Knowledge score for family planning was calculated for each respondent using a 10-point knowledge scale. Each correct answer had a score of 2, an incorrect answer or a no response had a score of 0 and the open-ended questions had a score of 4. The scores were then summed up to give a composite knowledge score for each respondent. The higher the score, the higher the knowledge and vice versa. Respondents with a score of 3 and below (25.6%) have low knowledge; those with a score of 4 to 7 (54.4%) have fair knowledge and those with a score of 8 to 10 (20.0%) have high knowledge (See details in Table 2).The mean knowledge score of respondents family planning and its methods was 4.47 ± 2.5 which indicates fair knowledge.

**Knowledge and Practice of Safe Therapeutic Abortion Services**

Respondents had a poor understanding of safe therapeutic abortion services, in fact there were queries as to whether abortion can ever be safe. The general meaning of safe abortion as reported by respondents was *"the removal/termination of unwanted pregnancy".* Other terms used include: *"killing of babies, flushing out pregnancy, getting rid of unwanted pregnancy, doing it the right way, abortion without complication, abortion that is well done, the abortion that you do and did not die from it, removal of unwanted pregnancy in a safe manner/by health professional/in a safe secure way".*

Only 8.3% of the respondents had ever heard of misoprostol and its use for termination of pregnancy. Reported channels of information about misoprostol were from friends/peers, internet, pharmacy/medicine store, school and doctor's prescription. Knowledge score for safe abortion was calculated for each respondent using a 10-point knowledge scale. The scores were summed up to give a composite knowledge score for each respondent. The higher the score, the higher the knowledge and vice versa. Respondents with a score of 3 and below (25.6%) have low knowledge; those with a score of 4 to 7 (54.4%) have fair knowledge and those with a score of 8 to 10 (20.0%) have high knowledge (See details in Table 2).The mean knowledge score of respondents about safe therapeutic abortion and medications was 1.92 ± 1,1 which indicates low knowledge.

**Table 2: Knowledge and Attitudinal Scores for Family Planning and Safe Abortion**

| Variable | Frequency | Percentage (%) |
|---|---|---|
| **Knowledge score for family planning** | | |
| 0 – 3 (Low) | 138 | 25.6 |
| 4 - 7 (Fair) | 294 | 54.4 |
| 8 – 10 (High) | 108 | 20.0 |
| Total | 540 | 100.0 |
| **Knowledge score for Safe Abortion** | | |
| 0 – 3 (Low) | 492 | 91.1 |
| 4 – 7(Fair) | 48 | 8.9 |
| 8 – 10 (High) | 0 | 0 |
| Total | 540 | 100.0 |
| **Attitudinal Score** | | |
| 0 - 5 (negative) | 273 | 50.6 |
| 6 - 10 (positive) | 267 | 49.4 |
| Total | 540 | 100.0 |

## IV. DISCUSSION

The findings from the survey clearly show that adolescent girls and young women had limited and incomplete information about family planning and safe abortion. Lack of awareness, inadequate information, and significant barriers posed by the current state of most sexual and reproductive services are perceived as unwelcoming to these young clients. The lack of reliable sources was consistent with the findings of other studies that discovered that most of the information received by adolescent girls and young women were often reinforced by the misconceptions and wrong information [10]. Findings showed that contraceptive use was typically low. Condom use was the most common methods of contraception known and practiced. This is so, because clients had easier access to it as was found in other studies [11]. The low usage could be as a result of the lack of awareness or ignorance about family planning and safe abortion services among adolescent girls and

young women as found in the study. Additionally, the study shows poor knowledge and attitude about safe therapeutic abortion by non-physician health providers, resulting from limited training on use of medication for termination of pregnancy. The poor awareness of the use of Misoprostol for the termination of unplanned pregnancy and other maternal health related issues among the study group could be attributed to the associated immorality and criminalization of abortion in Nigeria.

An analysis of the qualitative data gathered, revealed that the perception of health providers in family planning and safe abortion delivery plays an important role in effective provision and usage of these services. These community-based health providers understood the various reproductive and sexual health challenges of adolescent girls and young women because they live with them and as such are in the best position to counsel them. Some of the providers are experienced in basic FP service delivery especially those in the public PHCs and private hospitals. Service Providers' approval of the provision of method mix through pharmacies, PMVs, clinics, PHCs and hospitals indicates that family planning services should continue to be provided from a variety of service points [7]. Beyond government set targets for increasing contraceptive prevalence rate, support through promotional materials, educational opportunities and training would be acceptable to providers at the community level especially for adolescent girls and young women in female dominated workplaces.

Despite the high level of awareness of family planning, there is a huge gap between awareness and use; the overall conclusion would be that knowledge does not necessarily translate into attitudinal change where family planning use is concerned[12]. Currently, the federal government's policy stipulated role in family planning delivery includes procurement and distribution of methods, training of health professionals and mass media communication programmes, in collaboration with non-governmental organizations (NGOs) and aid agencies. Government should take these roles seriously especially in the area of commodity supply. All the informants from public PHC facilities lamented recurring stock-outs and commodities re-supply challenges. There are demands for contraceptive uptake though more among married women but there is inadequate commodities to meet the demand. These institutional limitations (commodities shortages and stock-outs) of access to safe and effective methods of family planning and health providers' attitude are issues of concern and should be addressed especially with the increased sexual activity among adolescent girls and young women.

This study shows poor knowledge and attitude about safe therapeutic abortion by non-physician health providers, resulting from limited training on use of medication for termination of pregnancy. With the high requests for induced abortion and a staggering mortality rate from unsafe abortion, it is obvious that there is need for interventions to address the issue to increase the uptake of modern family planning methods and safe abortion services. It is noteworthy that the abortion law is not the major deterrent to provision of safe abortion services in Nigeria but pure moral/cultural/religious beliefs and thus adequate training of community based providers will potentially increase safe abortion services and improve maternal health.

## V. CONCLUSION

Major gaps abound in knowledge, attitude and practice of family planning and safe therapeutic abortion among out-of-school adolescent girls and young women as found in the survey. Unfortunately, the community health gatekeepers who are in the position of educating these group of women and girls are either morally biased or lack adequate information on the issues relating to family planning and safe abortion. There is need for proper orientation and health education campaigns targeting young females engaged in out-of-school vocational skills through peer influence, community involvement and grass root seminars. In addition, the government and NGOs can play a more active role in supporting providers by offering training opportunities as well as distributing materials to enable providers promote family planning in general. Lastly, strengthening provider - community partnership through these mechanisms has the potential to increase both the availability and quality of family planning delivery, abortion safety and general maternal health and well-being in Nigeria.

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